Ethics

Assisted dying: the ongoing debate

D Harris, B Richard, P Khanna

Assisted dying remains highly topical and debated, both in the public and medical arena. All practising physicians in the UK who care for dying patients should be aware of the proposed legislation and the potential effects on their clinical practice.

Physician assisted death is a legal activity in certain parts of the world but not presently the UK (for example, the state of Oregon following the 1997 Death with Dignity Act and in the Netherlands under the 2001 Termination of Life on Request and Assisted Suicide Act).[1] Surveys suggest around 56% of doctors and 82% of the general public favour assisted dying.[2 3]

If legalised, it is estimated that 13 000 deaths a year may result from physician assisted suicide in the UK.[4] The debate regarding physician assisted death is complex involving many legal, ethical, medical, sociocultural, personal, and religious issues.

In this article we describe the important provisions of the proposed Assisted Dying for the Terminally Ill Bill in the UK and summarise the arguments for and against such legislation.

ASSISTED DEATH: DEFINITION OF TERMS

Before elaborating on the Bill and for and against arguments it is necessary to clarify terms relating to assisted death (table 1). ''Assisted death'' incorporates both physician assisted suicide and voluntary euthanasia, and the current version of the bill only relates to physician assisted suicide.

It is also important to note the legal and ethical ''distinction'' between physician assisted death and other end of life issues such as withdrawing and withholding life prolonging treatment, do not attempt resuscitation orders, and the appropriate provision of medication to relieve pain that may (but not necessarily) incidentally hastens death (the doctrine of double effect[7]).[1 8] Furthermore, while this distinction is made, it may be argued that morally these issues are indistinct from assisted death as all may hasten death.[9]

PROPOSED LEGISLATION FOR ASSISTED DYING IN THE UK

Background

In 2003 Lord Joffe introduced a bill (The Patient (Assisted Dying) Bill of 2003) to the House of Lords that, if enacted, would legalise assisted dying. The current version of the bill (the Assisted Dying for the Terminally Ill Bill of 2004)[10] is a revised version with a number of important amendments. In particular, the current proposed legislation would only legalise physician assisted suicide and not euthanasia and physicians who conscientiously object would not now be under an obligation to refer a patient requesting assisted suicide to another physician who would agree to do so.

The bill has been considered by a Select Committee of the House of Lords and debated in May 2006 at which time the majority of peers voted to delay the bill's second reading for six months.[11]

The Assisted Dying for the Terminally Ill Bill 2004

The purpose of the current proposed legislation is to ''enable an adult who has capacity and who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request; and for connected purposes''. Terminal illness being one that is inevitably progressive, the effects of which cannot be reversed by treatment, and that will be likely to result in the patient's death within a few months.[10]

In summary, the proposed legislation would mean that[10]:

(1) any patient considering assisted suicide would inform their physician in writing of their request
(2) the patient must be fully informed of their medical diagnosis, their prognosis and the process of being assisted to die
(3) the patient must also be informed (but not necessarily have experienced) of the alternatives to assisted dying ''included, but not limited to palliative care, care in a hospice and the control of pain'' by a palliative care doctor or nurse
(4) the physician must be satisfied that the patient does not lack capacity, that they have a terminal illness, and are ''suffering unbearably'' as a result
(5) The patient must also have been seen by a second ''independent'' physician who agrees these criteria are met
(6) If there is doubt about capacity then an opinion from a psychiatrist or psychologist is also required.
(7) If the above criteria are met the patient would then sign an independently witnessed declaration
(8) A period of 14 days must pass before assistance to die is made during which time that patient may revoke their declaration

While this bill has been opposed by a number of key organisations and colleges (notably the Royal College of General Practitioners,[12] the Association of Palliative Medicine,[13] and the British Geriatrics Society[14]), others have expressed a neutral position (for example, the British Medical Association[2 16]). This reflects the division of opinion among the medical profession itself. The Royal College of Physicians has recently changed its position from ''neutral'' to ''against'' a change in legislation (a synopsis of the position statements of these organisations is shown in table 2).

ARGUMENTS SUPPORTING ASSISTED DYING

Assisted dying and palliative care

Medical professionals supporting assisted dying suggest that even with the best palliative care, there will still be those terminally ill patients who make a rational request for euthanasia.[15 16] Modern palliative care may greatly reduce terminal suffering but may not always provide total relief of distressing symptoms and it is these patients that requests for assisted death are more prevalent.[17 18] In Oregon, 80%–89% of patients who have died by assisted suicide had received hospice care.[1 3]

There are concerns that legalisation of assisted dying would detract from the growing need for expanding palliative care services. However, the bill may have the opposite effect as all patients must have palliative care involvement before assisted dying taking place: similar requirements in the law in other countries (USA and Netherlands) where assisted dying is legal have lead to an improvement and greater development of palliative care services.[5 15 19]

In the state of Oregon, where the 1997 Death with Dignity Act legalised assisted dying, only 60% of people who get a ''lethal'' prescription actually use it.[15] It is suggested that the knowledge

Table 1 Physician assisted suicide and euthanasia: definitions of terms[1 5 6]

Physician assisted suicide	Making a means of suicide available to a patient with knowledge of the patient's intention to kill himself or herself. The final act resulting in death is undertaken by the patient (for example, taking pills provided by the physician).
Euthanasia	Someone other than the patient performs an act (for example, administering a lethal injection) with the intent to end the patient's life. Euthanasia derives from the Greek words ''Eu'' (good) and ''thanatos'' (death): a good death. Voluntary active euthanasia: act of killing a person at his or her request Involuntary active euthanasia: act of killing a person who, while competent opposes being killed Non-voluntary active euthanasia: act of killing a person who is incapable of making an informed request.

that assisted dying is available may itself aid wellbeing and reassurance (of the facility to control death).[15 19]

Public opinion

Medical professionals supporting assisted dying often relate to the wider public opinion on this issue that seems to favour assisted dying.[15]

Safeguards of the proposed legislation

In response to the concerns of those opposing the bill, advocates for the bill highlight the mechanisms and safeguards that it would contain to protect patients who lack the capacity to understand the significance of their decisions (for example, the need for involvement of two physicians and the involvement of a psychiatrist/psychologist where there is a concern regarding a patient's capacity).[15]

Concerns that assisted dying could be ''imposed'' upon vulnerable people has not been found in Oregon: people who have chosen assisted dying are generally younger, with above average educational attainment, higher socioeconomic class, and are not motivated by poor social support.[2 3 20] Equally the 14 day minimum period between the patients' decision and the act of assisted dying allows for changes in the patient's decision.

Ethical considerations

A comprehensive discussion of the ethical arguments for (and against) assisted dying is beyond the scope of this article. However, there are some key arguments that should be mentioned. Central to the argument supporting assisted dying is the ethical principle of respecting patient autonomy: that respect for a patient's wishes at the end of their life is paramount.[15]

Finally, a further concern of the medical profession has been the impact on the doctor-patient relationship (and on wider society) that assisted dying would have, there does not seem to be any evidence of an adverse effect in this regard in countries where assisted dying is already legal.[15 17 21] In addition, a recent survey of adults in the USA found that only one fifth would trust their doctor less if physician assisted death was legalised.[22]

Table 2 Synopsis of position statements of some key UK medical colleges and organisations

Royal College of Physicians (RCP)	Position: against Irrespective of whether the bill is enacted, it should be seen as a further signal to campaign for better care for dying patients including an extension of palliative care services and discussion of end of life issues in the face of changing values, ethnic diversity, and technological advance.[15a]
British Medical Association (BMA)	Position: neutral A neutral position entails a campaign for better palliative care, robust safeguards for patients, training for health professionals, and clear conscientious objection clauses.[2]
Royal College of General Practitioners (RCGP)	Position: against With improvements in palliative care, good clinical care can be provided within existing legislation and patients can die with dignity.[12]
British Association of Palliative Medicine (APM)	Position: against Palliative care strives to enhance patient dignity and choice towards the end of life. We need to improve access and provision of good palliative care rather than change the law.[13]
British Geriatrics' Society (BGS)	Position: against Rather than defining the conditions under which physicians may become killers, our efforts should focus on improving all aspects of palliative care such that the debate becomes irrelevant.[14]

ARGUMENTS AGAINST ASSISTED DYING

Assisted dying and palliative care

In contrast, it is argued that better terminal care and palliative care service development are what is needed rather than assisted dying: if patients have access to good quality palliative care at the end of life then assisted dying becomes unnecessary. Indeed, the Human Rights Act 1998 says that each person's life shall be protected by law and that society has a duty to prevent or alleviate the situation that they find intolerable.[23] One Dutch doctor has been quoted as saying ''we don't need palliative medicine, we practice euthanasia''.[23]

Logistical concerns regarding the proposed legislation

There are a number of concerns about logistical aspects of the proposed legislation such as: accurately estimating prognosis (particularly in non-malignant diseases), allowing the patient adequate time to change their mind, the ''independence'' of the second physician (if they are selected by the first physician they will probably share the same opinion), and excluding depression in those requesting death (distinguishing depression from a natural reaction to terminal illness is often difficult[5]).[14 15 23]

An additional practical concern is how the system will be regulated. In the Netherlands for example, there is evidence that euthanasia and assisted suicide are underreported by physicians despite the legal requirement to do so[1 4 15] and non-reporting seems to be associated with a lack of consultation with a second doctor.[24] A survey of medical practitioners in the UK has found that voluntary euthanasia and ending life without the explicit request of the patient does already occur, albeit very rarely.[6]

There is also little information about frequency of complications or unsuccessful assisted suicide and should either occur there is the potential to diminish the quality of end of life care, not improve it.[25 26]

Protection of vulnerable people and the ''slippery slope''

Perhaps the greatest concern is the protection of vulnerable people (for example, the elderly, disabled, and mentally incompetent),[14 23 24] and the

Table 3 Assisted death: ethical arguments[1 9 14–16 19]

Ethical principle	Argument supporting assisted dying	Argument against assisted dying
Respect for autonomy (that is, respect for individual choice)	Respecting patient free choice in decision making. A professional responsibility to respect patients' wishes.	The sanctity of life overrides individual autonomy
Beneficence (that is, doing good)	Doing good by ultimate relief of suffering and permitting the patient control in decision making at the end of life (compassion by the medical profession)	Assisted death constitutes abandonment by the medical profession
Non-maleficence (that is, doing no harm)	Refusal/inability to relieve suffering and address patients requests is harmful to the doctor patient relationship	Assisted dying is harmful to the doctor-patient relationship and the integrity of the medical profession in society
Justice (that is, societal implications)	Regulatory safeguards ensure that vulnerable members of society are not harmed by assisted dying	Vulnerable groups in society may be compelled to request assisted death

potential for such legislation to reinforce in society the attitude that ''suffering should not be a part of life, that interdependency is a burden, that the lives of disabled people are not worth living''.[23]

While it is true that white, educated, richer, and younger patients are more likely to engage in physician assisted suicide, it is the most vulnerable members of the population (for example, older people, minorities and those with physical and mental disability) that feel this sort of legislation would compromise their trust in the medical profession.[22] These concerns build to the ''slippery slope'' argument whereby voluntary requests for assisted death may evolve into involuntary euthanasia of vulnerable people.[17]

Physicians with conscientious objection

There would undoubtedly be physicians who conscientiously object to assisted suicide should it be legalised. While the original draft of the bill did not put a physician under obligation to assist death, it did require those objecting to refer the patient to another physician ''without delay''. This was met by significant objection from those opposing the bill (an obligation to refer the patient to a physician who is prepared to assist their death being complicity in killing)[8] and the current version has removed this obligation.[10]

Ethical considerations

Central to the argument for assisted dying is respect for patients' autonomy, but how far does patient autonomy go in modern society—if assisted dying is legalised could a non-terminal patient autonomously request assisted death?[15] Equally, the argument of patient autonomy has to be balanced against a respect for human dignity and the reverence for life.[1]

A further important concern of those opposing the legislation is the potential impact on the doctor-patient relationship and the relationship between the medical profession and British society in general [14 17]: particularly given the British media's attention and criticism in recent years.[15]

CONCLUSION

An entitlement to a ''good death'' has been given importance in most cultures and principles of a good death have been defined.[27 28] However, where a person perceives physician assisted death to be a component of their good death this must be balanced against wider implications for society as a whole.

Holistic palliative care addresses bio-psycho-social and spiritual issues at the end of life. However, some would argue that relief of all suffering at the end of life is not always possible thereby defining a role for physician assisted death.

Physician assisted death is controversial on the balance of a variety of arguments: legal, medical, ethical, and religious. Both proponents and opposers of assisted death are able to use fundamental bioethical principles to support their argument (Beauchamp and Childress's four principles of biomedical ethics is one approach to summarising these arguments (table 3)).

The medical profession and wider society as a whole remains divided as to whether physician assisted death should be legalised in the United Kingdom.

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Authors' affiliations
D Harris, B Richard, P Khanna, Department of Adult Medicine, Nevill Hall Hospital, Abergavenny, UK

Correspondence to: Dr D Harris, 15 Llwyn Y Grant Terrace, Penylan, Cardiff CF23 9EW, UK; dgharris@doctors.org.uk

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ADDENDUM

After this editorial went to press the British Medical Association also announced that it was changing its position from one of ''neutrality'' to ''against'' the proposed legislation (after a vote of members at its annual conference). The BMA opposes PAS and euthanasia ''as alien to the moral focus of medicine''. It argues that legalisation would change the doctor-patient relationship and put pressure on sick people.

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Key points

- Legislation is currently under proposal in the UK to legalise physician assisted dying.
- The debate regarding physician assisted death is complex involving many legal, ethical, medical, sociocultural, personal, and religious issues.
- Both proponents and opposers of assisted death are able to use fundamental bioethical principles to support their argument: autonomy, beneficence, non-maleficence, and justice
- The medical profession and wider society as a whole remains divided as to whether physician

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CORRECTION

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An editorial error occurred in this paper by Dr S Khan and others (2006;**82**:353–4). The authors' affiliations should read: S Khan, Department of Immunopathology, St Bartholomew's Hospital, London, UK; S Khan, D Subedi, M M Chowdhury, Department of Dermatology, University Hospital Of Wales, Cardiff, UK.